CALIFORNIA HEALTH ADVOCATES

Medicare Advantage (Part C): An Overview

Medicare Advantage Plans fall under Medicare Part C. A Medicare Advantage (MA) plan is an alternative to Original fee-for-service Medicare and a Medicare supplemental insurance policy (also known as Medigap policies). Medicare sponsors MA plans as part of the Medicare program and pays the plans to manage beneficiaries' health care. In order to join one of these plans, you have to have both Medicare Part A and Part B and you must continue to pay the Part B premiums ($93.50 in 2007). You receive all Medicare-covered benefits through the private plan chosen. These benefits can include prescription drug coverage; note that some Medicare Advantage plans offer Medicare Part D prescription drug coverage (known as "MA-PD" plans), and other plans do not (known as "MA-only" plans). Most Medicare Advantage plans have extra benefits and lower co-payments than the Original Medicare plan. However, you generally have to see doctors who belong to the plan or go to certain hospitals to get services.

There are five types of Medicare Advantage plans:

1. Medicare Health Maintenance Organizations (HMOs)
2. Medicare Preferred Provider Organizations (PPOs)
3. Medicare Private Fee-for-Service Plans (PFFS)
4. Medicare Special Needs Plans (SNPs)
5. Medicare Medical Savings Accounts (MSAs)

In addition, private Medicare plans can offer Provider Sponsored Organizations (PSOs), although there do not appear to be any PSOs available in California in 2007.

Medicare HMOs

Medicare HMOs (*Health Maintenance Organizations*) provide comprehensive health care to members who have Medicare Parts A and B. If you join a Medicare HMO, you are still on Medicare, and you retain the full rights and protections of a Medicare-eligible person. HMOs are the most popular kinds of Medicare Advantage plans in California, but they are not available in every part of the state.

When you enroll in a Medicare HMO, you will be required to use only doctors and facilities that contract with that particular HMO. You will have a primary care doctor who manages your health care needs. Before you see a specialist through your HMO network (except for an OB-GYN), you must generally get a referral from your primary care doctor. This requirement will be waived in such cases as emergency care, out-of-the area urgent care, or with a pre-approved referral to a doctor outside the network. If your current doctors are not under contract with the HMO, you must select new physicians who are part of the HMO network.

If you want to see a doctor outside the plan, and you do not have a pre-approved **referral**, you cannot use your Medicare card to pay for these services. You will have to pay for some, or possibly all, of the costs of your care. This is in contrast to care covered by Original Medicare with a Medigap policy, where you can choose to see any doctor you want who accepts Medicare patients. Some HMOs offer Medicare Part D prescription drug coverage and others do not; if you are in an HMO plan that does not offer Part D coverage, you generally cannot get other Part D coverage outside your plan

Some HMOs offer a Point-of-Service (POS) option. If yours does, then you are allowed to see doctors out of the HMO's network. Usually, however, HMOs charge for this option and may limit when you may use it.

Medicare PPOs

Medicare PPOs (*Preferred Provider Organizations*) use many of the same rules as Medicare

HMOs. Generally, in a PPO, you can see any doctor or provider who accepts Medicare. You do not generally need a referral to see a specialist or any provider out-of-network. If you do go to doctors, hospitals, or other providers who are not part of the plan ("out-of-network" or "non-preferred"), you will usually pay more.

In 2007, two regional PPOs are available statewide in California. Like local PPOs, regional PPO members can get Medicare prescription drug coverage through their PPO plan. While there are deductibles that must be met before coverage will start, regional PPO members also have an annual limit on their out-of-pocket costs, which will vary depending on the plan. In addition, local PPOs are available in certain counties.

Medicare PFFS Plans

Medicare PFFS (*Private Fee-for-Service*) Plans are offered by private companies and allow you to go to any Medicare-approved doctor or hospital *as long as they accept the terms of your plan's payment*. Members of these plans should make sure that their doctors and other health care providers accept the plan's rules before they receive services. You may get extra benefits not covered under Original Medicare, such as extra days in the hospital. The private company (not Medicare) decides how much it will pay and what you pay for the services you receive. Providers must agree to bill the plan for their services, not Medicare. You can get Medicare prescription drug coverage through your PFFS if it is offered. If it isn't offered, you can join a separate Medicare prescription drug plan (PDP).

Medicare Special Needs Plans

These plans may limit all or most of their membership to people in certain long term care facilities (like a nursing home), or those who are eligible for both Medicare and Medi-Cal ("dual eligibles"), or to those with certain chronic or disabling conditions. These plans are designed to provide health care and services to those who can benefit the most from things like special expertise of the plans' providers and focused care management. They must also provide Medicare prescription drug coverage. In most of these plans, there are generally extra benefits and lower copayments than in the Original Medicare Plan. These plans are available in some, but not all, areas of California.

Medicare Medical Savings Accounts (MSAs)

Medicare MSAs (*Medical Savings Accounts*) will be available for the first time in California in 2007. MSAs have two parts: 1) a high deductible health plan that covers Medicare Parts A and B services once the high deductible is met; and 2) a medical savings account – an independent bank account into which Medicare makes a deposit, which can be used to pay for health care services (including meeting the health plan deductible). Note that the deposit amount Medicare makes -- at least in the first year – will be less than the deductible that an individual must meet before health services are covered. MSAs cannot offer Part D prescription drug coverage, so MSA enrollees can enroll in a separate Medicare prescription drug plan (PDP).

Costs and Benefits

Medicare Advantage plans contract with Medicare on an annual basis. Medicare pays the plan a fixed monthly amount for each Medicare enrollee. This amount is readjusted each year based on a formula created by Medicare and it varies from county to county. In turn, the plan must provide, as a minimum, all Medicare covered services. It may also choose to provide additional services; these additional services can vary by specific geographic areas. Based on the monthly amount it receives from Medicare, the plan takes the financial risk of providing all medically necessary services, and still making a profit, regardless of how many or how few people use their services, how often services are provided, or how costly the services might turn out to be.

MA plans may provide extra benefits not covered by Medicare, such as preventive care, hearing, dental, and eye exams. Monthly premiums vary from region to region, and the range can be from a zero premium to more than $100 a month. Additionally, most MA plans require a co-payment for doctors' office visits and other services. Co-payments for some services, such as hospital care, can be as much as $992 in 2007 for each hospital admission. The California HMO Guide For Seniors, produced by the University of California

and the State of California Office of the Patient Advocate is a good resource to learn about how managed care plans work. It can also help you understand your rights so you can get the most out of your plan. You can obtain a free copy at http://www.opa.ca.gov/education/hmoguide_en.pdf

Many Medicare Advantage (MA) plans offer prescription drug coverage. These plans are often referred to as an MA-PD. If you enroll in an MA-PD, you do not need to enroll in a stand-alone Prescription Drug Plan (PDP). If you enroll in a Medicare Advantage (MA) plan that does not offer prescription drug coverage, you will need to obtain creditable prescription drug coverage elsewhere.

Enrollment

You cannot be denied enrollment in a MA plan if you have Medicare Parts A and B. Your Part B monthly premium will continue to be taken out of your Social Security or railroad retirement check.

If you have been diagnosed with End Stage Renal Disease (ESRD, also known as kidney failure) you are not eligible to enroll in a MA plan (in most cases). But if you develop ESRD while already enrolled in a MA plan, the plan cannot disenroll you. With the exception of ESRD, you cannot be denied enrollment in a MA plan due to a pre-existing condition.

If you want to join a MA plan, you must reside in the plan's service area and enroll during an applicable enrollment period (see Note below). Submit your application directly to the plan or a plan sales representative. Enrollment is usually effective on the first of the month following the month you submitted your enrollment application. You cannot receive coverage for medical care by the MA plan providers until enrollment takes effect. Remember not to drop your existing coverage, if any, until your coverage with your preferred MA plan is in effect.

Note: In the past, beneficiaries have been able to enroll into and disenroll from Medicare Advantage plans at any time during the year. Starting in 2006, Medicare beneficiaries are only able to enroll into and disenroll from MA plans during certain times of the year, including: 1) the Annual Enrollment Period (from November 15th through December 31st each year); and 2) the Open Enrollment Period (from January 1st through March 31st each year), with certain limitations.

This Open Enrollment Period is different for people who are newly eligible for Medicare. For example: you may be eligible to enroll in a Medicare Advantage plan if you just turned 65, or your COBRA coverage ended, or you are under age 65 but are now eligible for Medicare Part A and B due to a disability, or your spouse's health coverage ended. For more information, see our series of fact sheets on Supplementing Medicare (www.cahealthadvocates.org).

If you want to get out of an MA plan, and you don't want to join another plan at the same time (see below) you must send a written request to the plan or call 1-800-MEDICARE during the allowable enrollment periods mentioned above. Your disenrollment will be effective the first of the month following the month in which you made your request to disenroll. Medicare will not pay if you use providers and services outside of the MA plan's network until the effective date of your disenrollment. Remember that Medicare pays MA plans for your care at the beginning of each month. If you require medical care prior to the end of the month in which you requested disenrollment from your MA plan, you must seek treatment from this same MA plan, or you will be responsible for paying for out-of-network services.

When you do make the decision to change from one Medicare Advantage plan to another MA plan, simply submit an enrollment application to the new plan and you will automatically be disenrolled from the current plan. Remember that, in general, you can only make these changes during the Annual Enrollment Period and the Open Enrollment period.

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The Health Insurance Counseling and Advocacy Program (HICAP) provides free, objective information and counseling on Medicare and other related topics. You can call **1-800-434-0222** with your questions or to make an appointment at the HICAP office nearest you. To find the HICAP office in your area, visit http://www.calmedicare.org/counseling/.